EVOLUTIONARY HEALING INSTITUTE

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

By checking the lines below, I authorize being contacted for practice reminders by:

Mail:_____ By Voice Mail:_____

Email:_____ By Text Message:_____

Telephone Numbers:_____ By Facebook Address:_____

By checking the lines below, I authorize being contacted for birthday greetings or promotions about the practice by:

Mail:_____ By Voice Mail:_____

Email:_____ By Text Message:_____

Telephone Numbers:_____ By Facebook Address:_____

By checking the line below, I authorize the doctor to personally discuss with me products that may benefit my health or condition. _____

_____ _____

Patient Name (Printed or Typed) Date

_____

Parent, Guardian or Patient's Legal Representative

_____

Signature of Patient, Guardian or Patient's Legal Representative

List below the names and relationship of people to whom you authorize the Evolutionary Healing Institute to release PHI:

_____ _____

_____ _____

_____ _____

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

Please save this form and email to ehmiami@gmail.com

You will be asked to sign at the office.